Printed: 03/24/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		03/24	1/2015
	OVIDER OR SUPPLIER W MANOR OF PEABO	DDY	STREET ADDRE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	NITIAL COMMENTS			F 000			
	The following citations represent the findings of a Health Resurvey and Complaint Investigation #83733.						
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES			F 156			
	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.						
	The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.		e time the e ng se rs and de to hs				
	at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.						
LABORATOR'	Y DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIV	E'S SIGNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL IDENTIFICATION N		CLIA		(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		03/	24/2015	
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			STREET ADDRI 500 PEA PEABOL					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 156	Continued From pag	e 1		F 156				
	legal rights which ince A description of the medical care in his or down to Medicaid eligible A posting of names, a numbers of all pertine groups such as the S	nanner of protecting per ph (c) of this section; equirements and proce- ility for Medicaid, includent assessment under senines the extent of a con- est at the time of diattributes to the community share of resources which diavailable for payment entitutionalized spous ther process of spending	dures ding cition uple's munity ch se's ng					
	unit; and a statement complaint with the St agency concerning remisappropriation of refacility, and non-complicatives requirement. The facility must inforname, specialty, and physician responsible. The facility must prorwritten information, a applicants for admissinformation about how	and the Medicaid fraud of that the resident may fate survey and certificates and certificates desident abuse, neglect, esident property in the pliance with the advancates. If we each resident of the way of contacting the each ris or her care. Ininently display in the fand provide to residents	ille a tion and ee acility and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
	17E21			B. WING		03/2	24/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
WESTVIE	W MANOR OF PEABO	YDCY	500 PEABO	ABODY DY, KS 668	66			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 156	Continued From page	e 2		F 156				
	receive refunds for previous payments covered by such benefits.							
	The facility had a cen sample included 14 re observations and inte post the names, addr numbers of the pertin certification agencies resident may file a co	erview the facility failed to esses, and telephone ent state survey and with a statement that the mplaint with the state ares he/she received fo	e to ne					
	Findings Included:							
	- On 3/19/15 at 0920 AM, observation revealed the bulletin board utiized for resident information lacked the state agency contact information for complaints or concerns by residents or the public.		ition for					
	On 3/18/15 at 2:45 PM, Resident #30 stated he/she lacked knowledge on how to contact the appropriate state agencies for complaints about the care he/she received.							
	he/she lacked knowle	AM, Resident #47 state edge on how to contact ncies for complaints ab ved.	the					
	he/she lacked knowle	M, Resident #54 stated edge on how to contact ncies for complaints ab ved.						

	OF DEFICIENCIES F CORRECTION			` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		03/2	4/2015
	STREET ADDRESS, CITY, STATE, ZIP CODE VESTVIEW MANOR OF PEABODY PEABODY, KS 66866						
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MUS OR LSC ID		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 156	On 3/18/15 at 2:14 Phe/she lacked knowled appropriate state age the care he/she received the care he/she received the care he/she received the facility did contact information phe/she stated the me have an Ombudsman On 3/19/15 at 2:35 Pherified the facility did contact information pherified to grant procedure on 3/19/15, following Although requested, policy and procedure contact information for complaints on abuse funds, or non-complied directives. The facility failed to grant telephone numbers and certification for contact information for complaints on abuse funds, or non-complied directives.	M, Resident #32 stated edge on how to contact encies for complaints aboved. M, Social Service Staff do not have the state age osted for the residents. Ental health facility did not for a resident advocated for the state age osted for residents. A placed a printed copy numbers on the bulletin Director of Nursing's of the discussion. The facility did not provision posting the state age or resident use to voice on posting the state agor resident use to voice on posting the state agor resident use to voice on posting the state agor resident use to voice on posting the state agor resident use to voice on posting the state agor resident use to voice on posting the state agor resident use to voice on the pertinent state on agencies with a state on state on the pertinent state on agencies with a state on state on the pertinent state on agencies with a state on the pertinent state on agencies with a state on the pertinent state on agencies with a state on the pertinent state on agencies with a state on the pertinent state on agencies with a state on the pertinent state on agencies with a state on the pertinent state on agencies with a state on the pertinent state on agencies with a state on the pertinent state of the pertinent state on the pertinent state on the pertinent state of the pertinent state of the perti	the pout G encies not e. A encies of the n ffice, de a gency tion of	F 156			
F 167	state agencies about for the 50 residents v 483.10(g)(1) RIGHT	r file a complaint with the the cares he/she received who resided in the facilit TO SURVEY RESULTS	ved, ry.	F 167			
SS=C	A resident has the rig the most recent surve by Federal or State s	BLE Int to examine the resul yof the facility conduct urveyors and any plan ith respect to the facility	ted of				

Printed: 03/24/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		03/2	4/2015	
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
WESTVIE	W MANOR OF PEABO	DDY	500 PEABO	ABODY DY, KS 668	66			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 167	The facility must make examination and must accessible to resident their availability.	e the results available f t post in a place readily its and must post a noti	ce of	F 167				
	This Requirement is not met as evidenced by: The facility had a census of 50 residents. The sample included 14 residents. Based on observations, record review, and interview the facility failed to have the most recent survey, available for examination, in a place readily accessible for the 50 residents who reside in the facility.							
	Findings Included: - On 3/18/15 at 2:45 PM, Resident #30 stated he/she was of unaware where the most recent survey results were located and the location had not been discussed at the resident council meetings.							
	On 3/18/15 at 9:27 AM, Social Service Staff G stated the most recent survey results were kept in the administration office and not available after hours for the residents to view.		ept in					
	stated the most recent readily accessible to the past the residents had Administrative Staff A	e made to have the surv	ot n the					
	Although requested, t policy and procedure accessibility of the cu		de a					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
i i i i i i i i i i i i i i i i i i i							00 22.25	
		17E210		B. WING		03/2	4/2015	
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
WESTVIE	W MANOR OF PEABO	DDY		ABODY DY, KS 668	66			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 167	Continued From page 5			F 167				
	-	lace the most recent su eadily accessible to the in the facility.	- 1					
	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES			F 226				
	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.							
	This Requirement is not met as evidenced by: The facility had a census of 50 residents. Based on record review and interview the facility failed to provide written evidence that the facility conducted criminal background checks on the pre-screening of 2 of 5 employees reviewed. (#I, #J)							
	Findings Included:							
	stated the facility prev copy of the backgrour personnel files. He/sh began verifying the ba	5 AM, Administrative Stationary retained a printer and checks in the employers stated since the facility ackground checks on the sonly printed and retatified.	ed yee ity ne					
	verified the facility did	A, Administrative Staff A not have written verific bund checks in his/her						
	The facility's 10/01/01 Checks policy and pro	Criminal Background						

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		CLIA ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		03/	24/2015	
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			500 PEA	ESS, CITY, STATA ABODY DY, KS 6680				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T DEFICIENCE		HOULD BE	(X5) COMPLETION DATE	
F 226 F 329 SS=D	*The facility must inserected check on all a contacting local law state registries or renational clearinghou. *The results of all crinvestigations are completed by the results of all crinvestigations are completed by the reduced of the reduced by the facility failed to the facility conducte on the pre-screening outlined in the facility Checks policy. 483.25(I) DRUG REUNNECESSARY DISEACT resident's drug unnecessary drugs, drug when used in eduplicate therapy); without adequate missisteries or resident in the facility conducted the resident in the facility conducted in the facility co	stitute a further criminal applicants for employme enforcement authorities epositories, and/or state auses. Imminal background porfidential, must be filed /confidential file, unless by state law, and must be location in accordance arding personnel files. provide written evidence d criminal background c g of 2 employees (#I, #J'y's Criminal Background c GIMEN IS FREE FROM	in the e with e that hecks) as	F 226				
	should be reduced of combinations of the Based on a compretering resident, the facility who have not used a given these drugs u	ces which indicate the dor discontinued; or any reasons above. hensive assessment of a must ensure that reside antipsychotic drugs are inless antipsychotic drugy to treat a specific cond	a nts not					
	as diagnosed and d record; and resident drugs receive gradu behavioral intervent	ocumented in the clinical is who use antipsychotical dose reductions, and ions, unless clinically an effort to discontinue the	I :					

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION NI		CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		03/24	/2015	
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			STREET ADDRES 500 PEA PEABOL					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MUS OR LSC ID	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 329	Continued From pag drugs.	e 7		F 329				
	The facility had a cen sample included 14 reviewed for medicat observation, interview facility failed to ensur of unnecessary drugs	not met as evidenced besus of 50 residents. The esidents, of which 5 we ion regimen. Based on and record review the the drug regimen was for 2 of 5 residents and scheduled Tylenol. (see	e ere s free					
	assessment, dated 1 resident alert and orie Interview for Mental S independent to limite Activities of Daily Livi resident received schreported no pain, and antidepressive and d	ral (MDS) Minimum Data 1/10/14, indicated the ented with a (BIMS) Briestatus score of 15, and d assistance with (ADL: ng. The MDS indicated reduled pain medication of received antipsychotic furetic medications 7 data The quarterly MDS, data same.	ef s) the ns, c, ays of					
	summary for medication administer medication resident of the risks of	Care Area Assessment ion use directed the stans as ordered, educate of refusing medication, tion, and notify the phy-	the					
		n directed the staff to ns as ordered, educate of refusing medication,	the					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLII PLAN OF CORRECTION IDENTIFICATION NU			` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		03	/24/2015
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			500 PE	ESS, CITY, STATE ABODY DY, KS 66860	,		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENCY MI OR LSC		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329	observe for oversed if needed. The 3/5/15 physicial staff to administer T4 times daily, to the The 3/17/15 pharma recommended a dobenefit statement for mg of Tylenol, daily pharmacist recomm Nursing for the passiconcerns regarding resident received (4 when he/she recommended and the state of the state	dation, and notify the phy dation, and notify the phy an's order sheet directed a Tylenol, 1000 (mg) milligrate resident, initiated 9/25/0 acist consultant documer use reduction or risk versular the continued use of 40 and the continued use of 40 and the amount of Tylenol the old the amount of Tylenol the a	the ams, 7. Int us 0000 Tof e 1/15, n. S. sage as ase in e B 000 e sage e b e mum ber	F 329			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF DEAN OF CORRECTION UM			1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		03/24/	/2015
	ROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP CODE		
WESTVIE	W MANOR OF PEAB	ODY	500 PEA	ABODY DY, KS 668	66		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 329	hour period. The FDA "Severe liver damage than 8 (500 mg) table 24 hours, which is the Tylenol. The facility failed to econtinued maximum the resident at risk for excessive, long term. Resident #36's and Set assessment, date resident alert and orienterview for Mental Sindependent with (AEThe MDS indicated the scheduled pain medicand received antipsycantidepressive and dependent with the look back period. 1/18/15, indicated the moderate pain. The 10/20/14 (CAA) summary for medicate administer medication for oversedation. The 1/26/15 care pla encourage the reside and location, administer and location, administer and location, administer and location administer Tylenol, 1 daily to the resident,	A stated the label had to emay occur if you take ets, for a total of 4000 me maximum daily amount evaluate Resident #7's dosage of Tylenol, putting liver damage from the dosage. Inual (MDS) Minimum Dated 10/20/14, indicated ented with a (BIMS) Bric Status score of 15, and DLs) Activities of Daily Line resident received cations, reported no paid chotic, antianxiety, interest medications 7 dates ame except frequent on the dosage are except frequent. Care Area Assessment ion indicated nursing to me as ordered and observations as ordered and observations as ordered and observations. It is of pain medications, is needed. I's orders directed staff to 000 (mg) milligrams, 4 to 1000 (mg) mill	more ng, in nt for ng ata the ef iving. in ays of ted erve to ain ered, and	F 329			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE ID PLAN OF CORRECTION IDENTIFICATION NUI			` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		03/2	4/2015
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			500 PEA	ESS, CITY, STAT BODY DY, KS 6686			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGION OR LSC IDENTIFYING INFORMATION)		I .	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	pain in his/her hip waresident was managi Tylenol. Review of the month recommendations to the past 15 months, regarding the amoun received (4000 mg, che/she recommended. The 3/17/15 pharmar recommended a dose benefit statement for mg of Tylenol, daily. On 3/18/15 at 11:01 resident took his/her his/her neck upward. On 3/19/15 at 8:50 A resident does not constated he/she had not limitations for Tylenol here 2 days ago and the resident's dosage physician had ordere. On 3/17/15 at 3:55 P stated the resident hamg, daily, for a long the resident's physician hof Tylenol since 2010. The (FDA) Food and site, fda.gov, stated of use specific language maximum dosage in number of tablets that	as well controlled and the ng well with scheduled by pharmacist the Director of Nursing revealed no concerns to f Tylenol the resident daily) until 3/17/15, when do a dose reduction. Cist consultant documer to reduction or risk versus the continued use of 40 and the commended and the continued use of 40 and the commended and decress. Nurse G stated the continued use of and the commended and decress and a dose reduction. M. Administrative Nurse and received Tylenol, 40 and not changed the document of the continued	for the control of th	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E210		B. WING		03/	24/2015	
	OVIDER OR SUPPLIER W MANOR OF PEABO	DDY		RESS, CITY, STA	TE, ZIP CODE			
WESTVIL	W MANOR OF TEAD	1		DY, KS 668	66			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 329	read "Severe liver dan more than 8 (500 mg) mg, in 24 hours, whic amount for Tylenol. The facility failed to econtinued maximum of the resident at risk for	mage may occur if you tablets, for a total of 4 h is the maximum daily valuate Resident #36's dosage of Tylenol, putting liver damage from the	000 ng	F 329				
F 371 SS=F	authorities; and	CURE, ERVE - SANITARY sources approved or ry by Federal, State or stribute and serve food	local	F 371				
	The facility reported a Based on observation interview the facility fa	not met as evidenced bacensus of 50 residents n, record review and ailed to ensure the ice 's kitchen had a 2 inch	S.					
	facility kitchen reveals pipe rested inside the heavily soiled side of On 3/19/15 at 10:30 A	AM, Dietary Manager E ne drain pipe had no ai	n e					

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						GOIVII EE	COMIT EL LES	
		17E210		B. WING		03/2	4/2015	
				RESS, CITY, STA	TE, ZIP CODE			
WESTVIE	W MANOR OF PEABO	ץ ט ני		ABODY DY, KS 668	66			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 371	Continued From page 12			F 371				
	verified the maintenar drain pipe so it was not floor drain. The facility's July 200 ice bins directed the sanitizer and thorough of the ice storage bin sanitizer solution into document lacked inst drainage. The facility failed to e drainage system had	ructions for proper sani nsure the ice machine a 2 inch air gap in the ontrol purposes for the	for faces ess					
F 428 SS=D	IRREGULAR, ACT O The drug regimen of e reviewed at least once pharmacist. The pharmacist must the attending physicia	SIMEN REVIEW, REPON each resident must be e a month by a licensed report any irregularities an, and the director of ports must be acted up	d s to	F 428				
	This Requirement is not met as evidenced by: The facility had a census of 50 residents. The sample included 14 residents, of which 5 were reviewed for medication regimen. Based on observation, interview and record review the facility's pharmacist consultant failed to identify and address, in a timely manner, 2 of 5 sampled							

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17E210		17E210		B. WING		03/2	4/2015	
	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-		
WESTVIE	W MANOR OF PEABO	DDY		ABODY DY, KS 668	66			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	residents who receives scheduled Tylenol. (#Findings included: Resident #7's annuassessment, dated 1 resident alert and oriel Interview for Mental Sindependent to limited Activities of Daily Living resident received schoreported no pain, and antidepressive and dithe look back period. 2/8/15, indicated the standard for medication resident of the risks of observe for oversedar if needed. The 2/16/15 care plant administer medication resident of the risks of observe for oversedar if needed. The 3/5/15 physician's staff to administer Tyle 4 times daily, to the resident of the risks of the risks of the sident of the risks of the risks of the risks of the sident of the risks of the risks of the sident of the sident of the sident of the risks of the sident of the si	al (MDS) Minimum Data 1/10/14, indicated the ented with a (BIMS) Briestatus score of 15, and diassistance with (ADLsing. The MDS indicated eduled pain medication received antipsychotic uretic medications 7 das The quarterly MDS, dasame. Care Area Assessment from use directed the stans as ordered, educate frefusing medication, and notify the physical directed the stans as ordered, educate frefusing medication, tion, and notify the physical consultant documents on use directed the stans as ordered, educate frefusing medication, tion, and notify the physical directed the stans as ordered, educate frefusing medication, tion, and notify the physical directed the stans ordered, educate frefusing medication, tion, and notify the physical directed the stans ordered directed the enol, 1000 (mg) milligrates are standard documents of the physical directed the standard directed	a Set ef s) the is, ivys of ted ff to the sician the ams, 7.	F 428	DEFICIENCY)			
	recommended a dose reduction or risk versus benefit statement for the continued use of 4000 mg of Tylenol, daily. Review of the monthly pharmacist recommendations to the Director of Nursing for the past 15 months, revealed no		000					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		03/	24/2015	
	OVIDER OR SUPPLIER W MANOR OF PEABO	DDY	500 PE	RESS, CITY, STA ABODY DY, KS 668	,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 428	resident received (400 when he/she recommoder of the patiently in line for his medications with water on 3/19/15 at 8:50 All resident does not constated he/she had not limitations for Tylenol here 2 days ago and the resident's dosage physician had ordered on 3/17/15 at 3:55 Pl stated the resident ham g, daily, for a long tiresident's physician hof Tylenol since 2007. The (FDA) Food and site, fda.gov, stated in specific language refedosage in term of dos of tablets that should hour period. The FDA "Severe liver damage than 8 (500 mg) table 24 hours", which is the Tylenol. The facility pharmacis and address Residen maximum dosage of a trisk for liver damage term dosage.	ne amount of Tylenol the 200 mg, daily) until 3/17/ rended a dose reduction of MM, the resident stood of the medication, took for and had no problems of the medication. Nurse G to been aware of any dosuntil the pharmacist was recommended a decreated. Nurse G stated the did the decrease. M, Administrative Nurse is received Tylenol, 400 me. He/she verified the ad not changed the dose.	sage as ase in B B B B B B B B B B B B B B B B B B	F 428				

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		03/	24/2015
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY		500 PEA	ESS, CITY, STATA ABODY DY, KS 668				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE- OR LSC IDENTIFYING INFORMATION)		I	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	Set assessment, daresident alert and or Interview for Mental independent with (A The MDS indicated scheduled pain med and received antips; antidepressive and of the look back period 1/18/15, indicated the moderate pain. The 10/20/14 (CAA) summary for medical administer medication oversedation. The 1/26/15 care playencourage the resident and location, administer administer Tylenol, daily, initiated 10/12 The 1/27/15 physician administer tylenol. Review of the month recommendations to the past 15 months, regarding the amount received (4000 mg, he/she recommendations to the past 15 months, regarding the amount received (4000 mg, he/she recommendations to the past 15 months, regarding the amount received (4000 mg, he/she recommendations to the past 15 months, regarding the amount received (4000 mg, he/she recommendations to the past 15 months, regarding the amount received (4000 mg, he/she recommendations to the past 15 months, regarding the amount received (4000 mg, he/she recommendations to the past 15 months, regarding the amount received (4000 mg, he/she recommendations to the past 15 months, regarding the amount received (4000 mg, he/she recommendations to the past 15 months amount received (4000 mg, he/she recommendations to the past 15 months amount received (4000 mg, he/she recommendations to the past 15 months amount received (4000 mg, he/she recommendations to the past 15 months amount received (4000 mg, he/she recommendations to the past 15 months amount received (4000 mg, he/she recommendations to the past 15 months amount received (4000 mg, he/she recommendations to the past 15 months amount received (4000 mg, he/she recommendations to the past 15 months amount received (4000 mg, he/she recommendations to the past 15 months amount received (4000 mg, he/she recommendations to the past 15 months amount rec	ted 10/20/14, indicated riented with a (BIMS) Bristatus score of 15, and aDLs) Activities of Daily Lithe resident received dications, reported no paychotic, antianxiety, diuretic medications 7 data. The quarterly MDS, date same except frequent of the core are accept frequent ation indicated nursing to cons as ordered and observations as ordered and observations as ordered and consister medications as ordered staff the constant of the constant	ef Living. in Lays of Lited to Living and to Living and to Living and to Living and for to Living and for to Living and	F 428			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E210		B. WING	 	03/24/2015	
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			500 PE	RESS, CITY, STA ABODY DY, KS 668			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
	recommended a dos benefit statement for mg of Tylenol, daily. On 3/18/15 at 11:01 resident took his/her his/her neck upward On 3/19/15 at 8:50 A resident does not constated he/she had not limitations for Tyleno here 2 days ago and the resident's dosage physician had ordered on 3/17/15 at 3:55 P stated the resident himg, daily, for a long to resident's physician hof Tylenol since 2010. The (FDA) Food and site, fda.gov, stated on the specific language maximum dosage in number of tablets that a 24 hour period. The read "Severe liver day more than 8 (500 mg mg, in 24 hours", who amount for Tylenol. The facility's pharma identify and address use of the maximum the resident at risk for excessive, long term 483.60(b), (d), (e) DF 483.60(b), (d), (e) DF 584.	the continued use of 40 AM, observation reveals medications and stretch while swallowing. M, Nurse G stated the mplain of pain. Nurse G to been aware of any do I until the pharmacist was recommended a decreate. Nurse G stated the ed a dose reduction. M, Administrative Nurse ad received Tylenol, 400 time. He/she verified the end not changed the do b. Drug Administration we currently manufacturers be referring to Tylenol's term of dosage units, on at should not be exceed to FDA stated the label hamage may occur if you to the properties of the maximum dail control of the properties of the maximum dail ocist consultant failed to Resident #36's continued dosage of Tylenol, puttion liver damage from the dosage. RUG RECORDS,	sage as ase in e B 00 e sage must r total ed in had to take 0000 y	F 428			
		IGS & BIOLOGICALS		r- 4 31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	17E210			B. WING		03/2	24/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	<u> </u>		
WESTVIE	W MANOR OF PEABO	DDY	500 PE					
PEA				DY, KS 668	66			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	E ACTION SHOULD BE COMPLET DATE DATE		
F 431	Continued From page	e 17		F 431				
	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliation records are in order a controlled drugs is ma reconciled. Drugs and biologicals labeled in accordance professional principle appropriate accessory instructions, and the eapplicable. In accordance with St facility must store all clocked compartments controls, and permit controls are controls.	ifficient detail to enable in; and determines that and that an account of a aintained and periodical is used in the facility must with currently acceptes, and include the y and cautionary expiration date when tate and Federal laws, the drugs and biologicals in a under proper temperationly authorized personness.	tem an drug III III III III III III III III III I					
	controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: The facility had a census of 50 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to ensure appropriate labeling of an		to nit he					
			e					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E210		B. WING	 	03	/24/2015
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			500 PEA	ESS, CITY, STA ABODY DY, KS 668			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)		EDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 431	insulin pen in 1 of 1 r insulin dependent res Findings included: - On 3/16/15 at 8:35 observation revealed Levemir insulin pen, Nurse C verified the during the observation The 8/17/13 physicial Levemir Insulin Pen is administer Levemir 2 (beneath the skin) at On 3/19/15 at 1:15 P stated the nurses knoor the Insulin Vials w The 4/2007 facility In instructed, when oper record the expiration pen. The facility failed to expirate the state of	AM, during the initial to the medication room hot dated when opened insulin pen was not date on. In's order for Resident # instructed the staff to 15 units (sq) subcutaned hour of sleep. M, Administrative Nurse we to date the Insulin Phen opened. sulin Administration polining a new vial of insulindate and time on the views are the staff labeled mir insulin pen appropri	our, ad 1 I. ed #26's ous e B ens icy n,	F 431			